STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G641	A. BUILDING 00 B. WING	09/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK COMMUNITY SERVICES INC	1711 TREEN STREET LOGANSPORT, IN46947

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W0000	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: September 6, 7, and 8, 2011. Provider Number: 15G641 Facility Number: 001218 AIM Number: 100235390 Surveyor: Tracy Brumbaugh, Medical Surveyor III/QMRP. The following federal deficiencies also reflect state findings in accordance with 431 IAC 1.1. Quality Review completed 9/8/11 by Ruth Shackelford, Medical Surveyor III.	W0000		
W0137	The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, record review and interview, the facility failed for 3 of 3 clients who smoked, (clients #3, #4, and	W0137	**W137** Peak Community Services is committed to ensuring that clients	10/08/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	#6) to ensure cigarettes they purchased were available to them. Findings include: On 9-7-11 from 6:00 a.m. until 7:05 a.m. an observation at the home of clients #3, #4, and #6 was conducted. At 6:35 a.m. client #6 asked direct care staff (DCS) #4 for another pack of cigarettes. DCS #4 asked client #6 why he needed more and he indicated it was so he would have enough at work. DCS #4 got a set of keys and unlocked the closet door and gave client #6 a pack of cigarettes. At 6:40 a.m. on 9-7-11 an interview with DCS #4 indicated clients #3, #4, and #6 all purchased their own cigarettes and they were kept locked up. On 9-7-11 at 11:35 a.m. a review of client #3's Comprehensive Functional Assessment (CFA) dated 7-13-11 did not indicate he had a need for his cigarettes to be locked up. On 9-7-11 at 11:45 a.m. a review of client #4's CFA dated 6-7-11 did not indicate he had a need for his cigarettes to be locked up. On 9-7-11 at 11:50 a.m. a review of client #6's CFA dated 5-19-11 did not indicate		have the right to retain and use appropriate personal possessions and clothing. A new procedure has been put into place by the SGL Manager and Coordinator regarding cigarette storage. Each client has a lock box in his room. Each client is in charge of his own key. This is in place for all clients in the home. SGL Coordinator will monitor this procedure to assure it is maintained as intended and clients have no rights violated. Currently, no other group home has clients who smoke. Should they begin smoking, a lock box system will be put in place for this client. Person Responsible: Bridget Neal, Residential Coordinator Kris Myers, SGL Manager Completion Date: 10-8-11	

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	he had a need for his cigarettes to be locked up. On 9-7-11 at 9:45 a.m. an interview with the Community Services Manager indicated the cigarettes should be kept by the individuals with each client having their own key to their cigarette lock box. 1.1-3-2(a)			
W0227	The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #2) to ensure he had a toileting goal included in his Individualized Support Plan (ISP). Findings include. On 9-7-11 at 9:30 a.m. a record review for client #2 was conducted. The D&E (Diagnostics and Evaluations) dated 4-09 indicated client #2 had a diagnosis of urinary incontinence. His ISP dated 8-30-11 did not indicate he had a goal/objective to assist him with his	W0227	**W227** Peak Community Services is committed to ensuring the individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c) (3) of this section. For client #2, there is now a goal in place for toileting and a restroom tracking sheet. To ensure that the deficient practice does not reoccur the SGL Manager will spot monitor all Comprehensive Functional Assessments and goals to assure all areas of need are addressed	10/08/2011

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	toileting needs. On 9-7-11 at 9:45 a.m. an interview with the Community Services Manager indicated client #2 did have urinary incontinence during the day and at night. She also indicated he had no goal to assist him with his toileting needs. 1.1-3-4(a)		for all group home clients in the individual program plans over the next three months. Person Responsible: Kris Myers, QMRP Bridget Neal, Residential Coordinator Kris Myers, SGL Manager Completion Date: 10-08-11	
W0382	The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the home, to ensure clients did not have access to the medications in the open medication room. Findings include: On 9-6-11 from 5:05 p.m. until 5:40 p.m. medication administration was observed. At 5:15 p.m. direct care staff #1 was observed to leave client #3's tote of medications which included Calcium 600, Divalproex 500 mg, Metformin 850 mg, Citalopram 20 mg, Citalopram 40 mg, Omeprazole 20 mg, and Loratadine 10 mg, out on the cabinet in the unlocked	W0382	**W382** Peak Community Services is committed to ensuring that all drugs and biologicals are kept locked except when being prepared for administration. A new procedure has been put into place for Residential staff to keep the key to the medicine lock box on their person during their shift so it is not accessible to unauthorized persons. The Residential Coordinator will spot check for this key procedure to be carried out correctly for three months on all shifts in this group home. All staff have already been trained on this new procedure. The SGL Manager will spot check for this key procedure to be carried out correctly for the next three months in other group homes,	10/08/2011

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	room while she went to get herself a bottle of water from the garage. Client #3 was in the kitchen while his medications remained out on the counter in the laundry room. Clients #1, #2, #3, #4, #5, and #6 were all home and had access to the medications. On 9-7-11 from 6:05 a.m. until 6:20 a.m. medication administration was observed. At 6:15 a.m. direct care staff #4 was observed to place client #6's Tramadol 50 mg for pain in a bag on the counter. At 6:30 a.m. the Tramadol 50 mg continued to be in the bag unsecured. At 6:45 a.m. the Tramodol for client #6 was still unsecured in the bag on the counter. At 7:00 a.m. the bag with the Tramodol for client #6 was moved to the kitchen table by direct care staff #4. Clients #4 and #6 sat at the table with the unsecured medication. Clients #1, #2, #3, #4, #5, and #6 were all home and had access to the medications. On 9-7-11 at 10:30 a.m. a record review of the facility's Medication Administration Policy (no date available) indicated medications in the group home were to be maintained under proper conditions of security. On 9-7-11 at 9:45 a.m. an interview with the Community Services Manager		also. The current Supervised Group Living Standard Operating Procedure is for all labeled prescription medications transported to the Day Service program by residential staff, so the medication will not sit in an unlocked location at any time. The medications that need delivered to Day Program will be taken out of the group home's locked storage area and kept on the Residential staff person until they are released to the Day Service staff. Upon receipt of the medications, the Day Service staff will place the medications into the Day Service locked medication storage area. All staff have been retrained on these procedures. The Residential Coordinator will monitor the procedure of residential staff transporting Clients #3 and #6's medications to the Day Service Program by spot checking for one month. The SGL Manager will spot check the morning storage procedure of Residential staff turning over the medications to Day Service staff and locking the medication in the Day Service locked storage area for two months. Bridget Neal, Residential Coordinator Kris Myers, SGL Manager Completion Date: 10-08-11	

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	indicated medications should kept locked until they are going to be administered. 1.1-3-6(a)			
W0383	Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the home, to ensure only authorized persons had access to the keys to the drug storage area. Findings include: On 9-6-11 from 3:20 p.m. until 5:45 p.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 5:05 p.m. the medication keys were observed to lay on the shelf in the unlocked laundry/medication room with access to anyone who walked by. At 5:05 p.m. direct care staff (DCS) #1 was observed to get the keys from the shelf in the unlocked room and assist clients #3 and #4 with their medications. At 5:15 p.m. DCS #1 was observed to leave the	W0383	**W383** Peak Community Services is committed to only authorized persons having access to the keys to the drug storage area. A new procedure has been put into place for Residential staff to keep the key to the medicine lock box on their person during their shift so they are not accessible to unauthorized persons. The Residential Coordinator will spot check for this key procedure to be carried out correctly for three months on all shifts. All staff have already been trained on this new procedure. The SGL Manager will spot check for this key procedure to be carried out correctly for the next three months in all other group homes, also. Bridget Neal, Residential Coordinator Kris Myers, SGL Manager Completion Date: 10-08-11	10/08/2011

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	keys dangled from the medication closet as she went to get herself a bottle of water. At 5:20 p.m. DCS #1 put the keys back on the shelf in the unlocked room. At 5:40 p.m. the House Manager assisted client #5 with his medications. She also was observed to get the keys off the shelf and unlocked the medication closet. At 5:45 p.m. the house manager put the keys back on the shelf in the unlocked room for anyone who walked by to have access to the medication closet keys. On 9-7-11 from 6:00 a.m. until 7:05 a.m. an observation at the home of clients #1, #2, #3, #4. #5, and #6 was conducted. At 6:00 a.m. the medication keys were observed to lay on the shelf in the unlocked laundry/medication area with access to anyone who walked by. At 6:30 a.m. the keys were on the shelf. At 6:45 a.m. the keys were on the shelf in the unlocked room. At 7:00 a.m. direct care staff #4 took the keys from the shelf and laid them on the kitchen table as clients #4 and #6 sat at the table. On 9-6-11 at 5:20 p.m. an interview with the House Manager indicated the door leading into the laundry/medication room did not lock and the door was kept open. On 9-7-11 at 9:45 a.m. an interview with the Community Services Manager			

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	indicated the keys were kept on the shelf in the laundry room for anyone to have access to. 1.1-3-6(a)			
W9999	State Findings 1. 431 IAC 1.1-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: Governing Body (3) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. This state rule is not met as evidence by: Based on record review and interview the facility failed to report 4 of 10 BDDS (Bureau of Developmental Disabilities Services) reports in a timely manner. Findings include:	W9999	**W9999** Peak Community Services is committed to reporting BDDS (Bureau of Developmental Disabilities Services) reports in a timely manner by telephone no later than the first business day followed by written summaries as requested by the division. The offending staff person to this rule was verbally counseled on reporting procedures and timelines on BDDS Incident Reporting following this incident. To prevent this from reoccurrence the BDDS Incident Report Committee reviews each report submitted for the date of the incident and the date reported. If incidents are found to be reported late, the chair of the committee counsels the staff member who was responsible for reporting as to their obligation to report incidents within 24 hours of the incident as required by regulation.	10/08/2011

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	On 9-6-11 at 11:20 a.m. a review of the facility's BDDS reports was conducted. A BDDS report with an incident date of 6-3-11 and a submit date of 6-6-11 for clients #1, #3, #4, and #5 indicated they were in a minor car accident which caused harm to vehicles but not to clients #1, #3, #4, or #5. The review indicated the BDDS reports were not filed within 1 day. On 9-7-11 at p.m. the Qualified Mental Retardation Professional indicated BDDS reports were to be filed within 24 hours. 2. 431 IAC 1.1-3-2(a) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: Resident Protections (3) The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check and three references. This state rule is not met as evidenced by: Based on record review and interview the facility failed for 1 of 2 sampled facility staff (staff #7) to provide three references. Findings include: Facility personnel records were reviewed		Peak Community Services will ensure that all employees will have completed references as called for by state regulations. Peak Community Services personnel have been trained on the appropriate employment practices that are needed prior to being employed in an SGL setting. Peak Community Services SGL Director will regularly monitor all employee files to ensure that all required information is included prior to new SGL staff being employed to work with clients in an SGL setting. Kris Myers, SGL Manager Kathi Thompson, SGL Director Completion Date: 10-08-11	

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	on 9-7-11 at 9:00 a.m. including the personnel record for staff #7. Staff #7's record only included 2 references. On 9-7-11 at 9:05 a.m. the Community Services Manager indicated 3 references should have been obtained for employment. 1.1-3-2(c)(3)			